

ATTACHMENT "A": EXCEPTIONAL COST FOSTER CARE

Instructions: Exceptional Reimbursement to Foster Parent:

This reimbursement rate is made to the foster parent because the child's behavior differs substantially from the behavior of most children of the same age in care. In the section Specific Nature and Justification of Request, describe the child's behavior(s) the frequency of the behavior(s), the foster parent activity required because of the behavior(s), and the goal the foster parent is trying to achieve by their activity.

Exceptional costs are either maintenance or non-maintenance. It is essential that you appropriately identify them for purposes of federal funding. If you are unsure about funding categories, contact your Regional Federal Funding Specialist or the Federal Funding Unit, Olympia, 360-902-7958

I. MAINTENANCE ITEMS AND ACTIVITIES

- A. Respite Care - Check hours or days as appropriate. Write the name of the provider.
- B. Special Diet - Any special diet must be approved by a doctor. Write the name of the doctor.
- C. Special Clothing - Explain nature of ongoing need.
- D. Special Equipment/Furniture - Explain what it is and why it is needed.
- E. Special Supervision - Explain extent of supervision and why it is needed.
- F. Other Needs - Explain maintenance item or activity not included in A-E.
- G. Subtotal. Total values of request A-F.

II. NON-MATENANCE ITEMS AND ACTIVITIES

- A. Classes/Lessons/and Social Activities. Briefly explain why requested.
- B. Therapy outside the statement of work in the psych/psych contract.
- C. Special Therapeutic Activities. Explain why the reimbursement is requested.
- D. Other. Explain non-maintenance item or activity no included in A-C.
- E. Subtotal. Total values of requests A-D.

III. TOTAL COSTS - SIGNATURE

- A. Total costs as requested on worksheet.
- B. Place monthly and total exceptional costs (maintenance and non-maintenance) in Section 2 on Exception Request Form and:
- C. Obtain signatures for approval

CHILD'S BIRTHDATE	PERMANENT PLAN		
IS CHILD DDD ELIGIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	TARGET DATE TO COMPLETE	PLANNED DISCHARGE DATE	
BUDGET WORKSHEET (FOSTER CARE)			
I. MAINTENANCE ITEMS AND ACTIVITIES (Federal Funded items)	COST PER MONTH OR UNIT	NUMBER OF MONTHS OR UNITS	TOTAL COST
A. Respite or child care (as a substitute for or to assist foster parent in caring for child.) <input type="checkbox"/> hours/ <input type="checkbox"/> days per month _____ multiplied by \$ _____ per <input type="checkbox"/> hours/ <input type="checkbox"/> days equals	Provider Name		
B. Special diet, DR's name: _____	_____	_____	_____
C. Special clothing (e.g. diapers, etc.) Explain: _____ _____	_____	_____	_____
D. Special equipment/furniture Explain: _____ _____	_____	_____	_____
E. Additional reimbursement to foster parent for special supervision. Explain: _____ _____	_____	_____	_____

I. MAINTENANCE ITEMS AND ACTIVITIES (Federal Funded items)		COST PER MONTH OR UNIT	NUMBER OF MONTHS OR UNITS	TOTAL COST
F. Other Needs _____		_____	_____	_____
G. Subtotal (use SSPS code 3216 for these costs)		_____	_____	_____
II. NON-MAINTENANCE ITEMS AND ACTIVITIES (Non_Federally Funded)		COST PER MONTH OR UNIT	NUMBER OF MONTHS OR UNITS	TOTAL COST
A. Classes/lessons/social activities (not related to physical care/supervision) Explain: _____		_____	_____	_____
B. Therapy (non psych./psych.) Name of individual or organization providing service. _____		_____	_____	_____
C. Special therapeutic intervention by foster parent. (behavior modification, physical therapy) Explain: _____		_____	_____	_____
D. Other Explain: _____		_____	_____	_____
E. Subtotal (use SSPS Code 3217 for these costs.		_____	_____	_____
III. TOTAL COST OF EXCEPTION PLAN AND FOSTER CARE		COST PER MONTH OR UNIT	NUMBER OF MONTHS OR UNITS	TOTAL COST
A. Total Maintenance (from I, G) _ _ _ _ _		_____	_____	_____
B. Total Non-Maintenance (from II, E) _ _ _ _ _		_____	_____	_____
C. Total Exceptional Cost Plan (place on Exception Request Form (DSHS 05-210)) (Note: costs in D, E & F do not go on Exception Request form) _ _ _ _ _		_____	_____	_____
D. Regular Foster Care Rate _ _ _ _ _		_____	_____	_____
E. Special Foster Care Rate _ _ _ _ _		_____	_____	_____
F. Agency Service Fee (if any) _ _ _ _ _		_____	_____	_____
G. Grand Total Cost of Care _ _ _ _ _		_____	_____	_____
WE HAVE DISCUSSED AND AGREE TO THIS EXCEPTIONAL COST PLAN				
FOSTER PARENT SIGNATURE (When available)			DATE	
FOSTER PARENT SIGNATURE (When available)			DATE	
DDD CASE MANAGER SIGNATURE (When appropriate)			DATE	
CHILD PLACING AGENCY REPRESENTATIVE SIGNATURE			DATE	